

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

August 23, 2018

Mr. Bimal Patel, President/CEO
William Backus Hospital
326 Washington Street
Norwich, CT 06360

Dear Mr. Patel:

Unannounced visits were made to William Backus Hospital concluding on June 5, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a licensure renewal inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **September 6, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

- (1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
- (2) the date each such corrective measure or change by the institution is effective;
- (3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
- (4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

An office conference has been scheduled for **September 18, 2018 at 10:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.



Phone: (860) 509-7400
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410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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DATES OF VISIT: April 9, 10, 11, 12, March 22 and June 5, 2018

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Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

We do not anticipate making any practitioner referrals at this time.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,



Susan H. Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN/LH:jf

Complaints #21783, 22429, 22954, 22509, 23184, 23052 and 23241

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services.

1. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for pain (Patient #8), the hospital failed to ensure the patient's pain monitored and/or efficacy of interventions were assessed. The finding includes the following:
 - a. Patient #8 presented to the ED on 4/8/18 at 1:11 PM with complaints of back pain. Review of the record with the Nurse Manager on 4/9/18 at 10:00 AM indicated that on 4/8/18 at 1:22 PM the patient had a pain level of 9 (0-10 scale) and Robaxin was administered at 2:03 PM and a Lidoderm patch was applied at 3:14 PM. The record failed to reflect a reevaluation of the patient to determine the efficacy of the Robaxin until 4/9/18 at 3:05 AM when the patient had a pain level of 7. Review of the policy indicated in part that staff should reassess the patient for pain after each pain management intervention within two hours after IM, SC or oral medications or prior to discharge.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2) and/or (4) (A) and/or (d) Medical records (3) and/or (i) General (6).

2. Based on a review of clinical records, interview and policy review, for one patient receiving mechanical ventilation (Patient #15), the hospital failed to ensure that the Mechanical Ventilation Protocol was comprehensive. The finding includes the following:
 - a. Review of Patient #15's clinical record indicated that the patient was intubated on 4/4/18 requiring mechanical ventilation. The physician's order directed "Mechanical Ventilation Protocol". Review of the protocol indicated that for FiO2 (fraction of percentage of inspired oxygen) initial setting should be 40%-100 % to maintain the patient's oxygen saturation greater than 90%. Review of Patient #15's respiratory record for the period of 4/4/18 through 4/7/18 indicated that the patient was initially set at 50% with a saturation of 97%, was decreased 45% on 4/5/18 and on 4/6/18 was changed to 55% based on a saturation of 92%. The protocol failed to direct the increments/decrement amount when making changes. Interview with the Director of Respiratory Services on 4/10/18 at 10:30 AM indicated that the standard is to change the FiO2 by 10% however this is not in the protocol.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

3. Based on a review of clinical records, and policy review, for one patient in restraints, (Patient #5), the hospital failed to ensure the patient was monitored in accordance with facility policy. The finding includes the following:
 - a. Patient #5 presented to the ED on 3/20/18 at 12:35 PM with alcohol intoxication. The

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record indicated that the patient was placed in four point restraints at 2:25 PM secondary to the behaviors of hitting, kicking and biting. The record indicated that the patient was monitored at the initiation of the restraints then again at 6:37 PM (four hours later) when range of motion was evaluated.

Review of the policy indicated patients in behavioral restraints are to be monitored every fifteen minutes for, in part, patient dignity and respirations. The policy further directed that patients should be monitored every two hours, in part, for vital sign assessments, elimination, injury, hygiene, and fluid needs.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1).

4. Based on a review of clinical records, and policy review, for one patient receiving hemodialysis, (Patient #16), the hospital failed to ensure the patient was weighed post treatment. The finding includes the following:
 - a. Patient #16 was admitted to the facility on 3/28/18 and required hemodialysis. Review of the hemodialysis flow sheets dated 3/29/18, 3/30/18 and 3/31/18 failed to identify that post-treatment weights were obtained.
The Post Treatment Patient Assessment Policy identified that a post treatment assessment is conducted, in part, to evaluate the effectiveness of the treatment and that patient care staff will obtain and document basic data on each patient including a post dialysis weight and compare to the pre-dialysis findings.

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5. Based on a review of clinical records, interview and policy review, for one of three patients' reviewed with complaints of chest pain, (Patient #35), the facility failed to ensure that an EKG was obtained timely and/or that abnormal vital signs were re-evaluated timely. The findings include the following:
 - a. Patient #35 presented to the ED on 2/22/18 at 9:50 AM with a complaint of "trouble breathing, feels like trouble with heart". The patient had a medical history in part, diabetes, sleep apnea, coronary artery disease, chronic obstructive pulmonary disease, and congestive heart disease.
 - i. The triage note on 2/22/18 at 9:59 AM indicated that reason for the visit was difficulty breathing for one week, swelling ankles and chest tightness. The patient was designated as a level three (3) acuity. Review of systems by the ED physician dated 2/22/18 at 12:15 PM indicated that the patient was positive for shortness of breath (SOB), negative for cough, and chest pain. Physical exam indicated a cardiac assessment of normal rate and rhythm, pedal edema and normal breath sounds.

Review of the physician orders at 9:59 AM, directed that an EKG be obtained.

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The record indicated that an EKG was completed at 12:10 PM, two hours after presentation. Interview with the triage nurse on 6/5/18 at 10:50 AM stated she did not remember the patient however when an EKG is ordered in triage, one of the technicians are directed to obtain the EKG. Interview with the ED Medical Director on 6/5/18 at 11:15 AM stated that the door to EKG time should be less than 10 minutes.

Review of the ED policy for assessments/ reassessments directed that patients will be seen after a short registration and that treatment will be determined by the severity of the presenting medical problem.

- ii. Review of Patient #35's vital signs indicated that at 10:00 AM the patient had a blood pressure of 182/125, pulse of 103, and respirations of 24. The record failed to reflect that the patient's blood pressure was reassessed until 12:02 PM, two (2) hours later. Interview with the Associate ED Director on 6/5/18 at 11:15 AM indicated that vital sign reassessment is an area of focus.

Review of the ED policy for assessments/reassessments indicated that the registered nurse will ensure that abnormal vital signs are repeated within 30-60 minutes.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

- 6. *Based on medical record reviews, review of facility documentation, review of facility policies and interviews for one of three surgical patients (Patient #4), the facility failed to ensure that objects were not unintentionally retained. The finding includes:

- a. Patient #4 was admitted to the hospital on 3/30/18 for a hemorrhoidectomy. The final surgical sponge count conducted by RN #2 and ST (Surgical Technician) #1 and documentation by RN #2 on 3/30/18 at 1:55 PM identified that the final sponge count was incorrect. The intraoperative record dated 3/30/18 identified that Patient #4 left the OR at 2:08 PM and arrived in the PACU (post- anesthesia care unit) with CRNA #1 (certified registered nurse anesthetist) at 2:13 PM. RN #2's addendum to the OR record dated 3/30/18 at 4:45 PM indicated that Patient #4 emerged from anesthesia in a thrashing manner in the OR which required immediate attention (by RN #2 and ST #1) for patient safety. Patient #4 was then transported to the PACU with CRNA #1 and upon returning to the surgical count, a Raytech 8 x 4 sponge was found missing. The progress note by MD #2 dated 3/30/18 at 2:46 PM identified that he was informed of the missing sponge when the Patient was in PACU, Patient #4 was immediately informed and taken back to the OR. Patient #4 received Propofol anesthesia, proctoscopy was performed and the retained sponge was removed. Interview with the Regional Director of Quality on 4/9/18 at 9:27 AM identified that she interviewed CRNA #1 after the incident and CRNA stated that she left the OR with Patient #1 because she believed that the final count had been completed. Interview with RN #2 on 4/12/18 at 10:10 AM noted that the sponge count was interrupted due to patient safety, MD #2 had left the room prior to the

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count completion and she did not realize that CRNA #1 and Patient #4 had left the OR. Interview with MD #2 on 4/12/18 at 11:58 AM indicated that he debriefed the team at the end of the OR case, left the OR, assumed that the final surgical count was in process and was informed of the inaccurate count when he was in PACU. Interview with the Director of Surgical Services on 4/12/18 at 10:46 AM noted that the universal protocol policy was not followed by the OR staff for this procedure. Interview with the Vice President of Medical Affairs on 4/12/18 at 1:52 PM noted that the operating surgeon was ultimately responsible for the care of the patient. The facility universal protocol policy identified that all surgical/procedural team members should participate in sign-out and de-briefing which shall address, in part, completion of sponge, sharps, instrument count or accounted for, including intentionally retained items inserted/or removed.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (a) Physical plant and/or (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

7. *Based on medical record reviews, review of facility documentation and interviews, the facility failed to ensure that the environment was safe on the BHU (behavioral health unit). The finding includes:

- a. Patient #14 was admitted to the medical unit on 3/30/18 with SI (suicidal ideation), depression and tachycardia. Patient #14 was placed on one to one observation. Patient #14 also had a recent history of suicidal attempt by hanging. Following medical clearance, Patient #14 was admitted to the BHU on 4/2/18 at 7:01 PM. The initial psychiatric assessment by MD #5 dated 4/2/18 identified that Patient #14 was at low risk for suicide due to being hospitalized. Nursing documentation dated 4/2/18 at 7:00 PM identified that Patient #14 had SI and would contact a staff member if he/she felt like hurting self.

Patient #19 had a history of at least 2 suicide attempts and was admitted to the medical unit on 4/1/18 with diagnoses that included alcohol abuse, seizures, depression, SI and was placed on one to one observation. Patient #19 was medically cleared and was admitted to the BHU on 4/4/18 at 2:56 PM. The initial psychiatric assessment by MD #5 dated 4/4/18 identified that Patient #19 had suicidal ideation with a suicidal plan of hanging and was at low suicide risk due to hospitalization.

A tour of BHU was conducted with the Unit Manager on 4/9/18 beginning at 9:35 AM. Observations identified that the unit had five occupied medical beds. The observations further identified that although modifications had been made to the beds to include shortened, secured cords and non-removable head and foot boards, multiple ligature points were observed on the bed frames and side rails. The observations also noted that

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Patients' #14 and #19 occupied two of the five medical beds. Review of facility documentation and interview with the BHU Manager on 4/11/18 at 1:22 PM noted that the medical beds had been on the BHU at least three years. Interview with MD #5 on 4/12/18 at 11:12 AM indicated that although she was unaware of the ligature points on the medical beds, she was aware that Patients #14 and #19 were placed in medical beds on the BHU and both patients felt safe in the hospital. Interview with the Regional Director of Quality and Safety on 4/11/18 at 2:15 PM and review of facility documentation indicated that an environmental risk assessment of the BHU was not conducted during 2017, was conducted on 1/31/18 and although the safety of the medical beds was discussed, the discussion or risk assessment had not been documented. Subsequently on 4/12/18, the facility began to replace the medical beds on the BHU.

- b. A tour of BHU was conducted with the Unit Manager on 4/9/18 beginning at 9:35 AM. Observations at 9:40 AM identified that the handicap shower room door was unlocked, partially open and unattended. Observation of the handicap shower room noted multiple ligature points to include sink hardware. Interview with the BHU Manager on 3/9/18 at 9:35 AM noted that the door to the shower room was to be kept locked when unattended and patients were always supervised when in the room. The BHU Manager subsequently closed and locked the handicap shower room door. The BHU environmental rounds sheet identified hourly rounding to ensure that the handicap shower room was locked and rounds were last conducted on 4/9/18 at 9:00 AM to indicate that the door was observed locked.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (i) General (6).

8. Based on medical record reviews, review of facility documentation and interviews the facility failed to ensure that physician restraint orders were complete for 3 of 4 patients (Patients #s 13, #20 and #21) who were restrained. The finding includes:
 - a. Patient #13 was admitted to the BHU (Behavioral Health unit) with diagnoses included psychosis. Patient #13's medical record dated 8/24/17 indicated that the patient was verbally assaultive, attempted physical assault, could not be redirected and was placed in 4-point restraints on 4/24/17 at 8:00 PM. Although the restraint order dated 8/24/17 indicated risk for self- harm/aggressive behavior as the reason for the restraint, the order lacked the behavior(s) that elicited the use of the restraints.
 - b. Patient #20 was admitted to the BHU for psychiatric management. Patient #20's medical record dated 7/25/17 indicated that the patient continued to be agitated and aggressive toward staff despite medication administration and was placed in 4-point restraints on 7/25/17 at 9:45 AM. Although the restraint order dated 7/25/17 indicated risk for self- harm/aggressive behavior as the reason for the restraint, the order lacked the behavior(s) that elicited the use of the restraints.

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c. Patient #21 was admitted to the ED on 3/20/18 with alcohol intoxication. Patient #21's medical record identified that the patient was argumentative, hostile and security was present. Physician orders dated 3/20/18 at 2:24 PM directed 4 point restraint and the reason for the restraint was danger to self. The order lacked the behavior(s) that elicited the use of the restraints.

Review of patient restraint orders with the Director of the BHU on 4/12/18 at 11:53 AM noted that a generic reason for behavioral restraint use was present for all behavioral restraint orders, was not specific and required only a check mark by the practitioner. The facility policy for restraint and seclusion identified that the restraint order must include, in part, the reason for the restraint seclusion.

The following is a violation of the Regulation of Connecticut State Agencies Section 46a-153.

9. Based on medical record reviews, review of facility documentation and interviews the facility failed to ensure that the facility included all required elements in the compilation of restraint use. The finding includes:

a. A review of restraint logs for the BHU (behavioral health unit) and ED (emergency department) was conducted on 4/12/18 with the Director of the BHU. The logs identified the following; name of the patient, order date/time, type of restrain, discontinuation date/time length of time in restraints and initials of the staff who initiated the restraint. The review also indicated that the restraint compilation (logs) lacked the nature of the emergency for the use of the restraint.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

10. Based on observation, review of clinical records, hospital policies and procedures and interviews for one of three patients who received multiple psychotropic medications and utilized the quiet/seclusion room (Patient #51) the hospital failed to provide adequate supervision to mitigate the risk to fall. The findings include:

a. Patient #51 was admitted to the in-patient behavioral health unit on 3/06/18 with diagnoses of major depressive disorder and hypothyroidism with chief complaints of increased anxiety and depression with suicidal thoughts. On 3/07/18 at 12:00 AM, Patient #51 presented as anxious, tangential, and reported racing thoughts. A Fall Risk Screen documented at 1:00 AM identified as a low fall risk. On 03/07/18 at 6:36 AM the patient was described as responding to internal visual and auditory stimuli, knocking on egress doors, and searching for people who did not exist. Attempts to redirect were unsuccessful. At 2:08 PM the patient expressed delusional thinking. A Fall Risk Screening documented at 7:00 PM identified a low risk score of one. At 10:46 PM the

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hallucinations and delusions continued, MD #32 was contacted, Patient #51 received Chlorpromazine 50 mg and Diphenhydramine 25 mg intramuscularly and willingly went to the quiet room with the door open.

On 3/8/18 at 12:30 AM, RN #31 documented that Patient #51 was floridly psychotic with visual and auditory hallucinations. He/she required assistance of two staff for ambulation to the bathroom and returned to the quiet room for safety. The patient was described as restless, crawling on the floor, and disrobing. RN #31 documented that a sitter was requested for Patient #51, however none were available, and that staff would continue close observation of the patient.

On 3/8/18 at 1:33 AM, RN #31 identified that the patient remained restless, yelling out at times, talking to him/herself and unable to settle. Lorazepam 2 mg was administered for anxiety/agitation. At 2:00 AM, RN #31 documented that Patient #51 was observed via video monitor from the nursing station to be standing up and while the staff was on route to the quiet room to provide assistance, the patient fell. The patient was observed to be prone on the floor with his/her head against the wall with the neck flexed back. MD #34 was notified and the patient was assessed by MD# 31. A Fall Risk Screening dated 3/8/18 at 2:00 PM identified a high score of thirteen.

Interview with RN #3, the 3:00 PM to 11:00 PM nurse on 3/7/18 identified that Patient #51 began hallucinating after receiving his/her evening medications. A mental health worker (MHA) stayed with the patient and RN #3 contacted MD #32 who ordered an oral antipsychotic medication. The patient tried to enter other patient's rooms and attempted to dig in the floor presenting a danger to his/her self and others. RN #33 again contacted MD #32 who ordered two additional medications to be administered intramuscularly. The patient accepted the medications. RN #33 identified that he/she decided to move the patient into the quiet room for his/her own protection, to decrease stimuli, and be more visible on the video surveillance camera monitor at the nursing station. Patient #51 fell asleep on the mattress positioned on the floor in the quiet. RN #33 identified that the patient did not appear unsteady on her feet prior to falling asleep on the mattress. RN #33 gave report to RN #31 and RN #32.

Interview with MD #33 on 3/22/18 at 11:30 AM identified that Patient #51 exhibited no signs or symptoms of psychosis when he conducted the initial psychiatric evaluation, however, he/she started the patient on Seroquel 100 mg PO qhs for patient complaint of insomnia.

Interview with RN #31 on 3/22/18 at 3:15 PM identified that he/she had worked the night of 3/7/18 into 3/8/18 and received report at approximately 11:45 PM. The report included that Patient #51 had become psychotic after receiving a dose of Seroquel. The patient had been sleeping in the quiet room with the door open and RN #31 assisted him/her to the bathroom as he/she was unsteady with ambulation and required direction. Patient #51 could move, but could not stand unassisted. The patient was crawling on the

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floor, disrobing, and attempting to stand. RN #31 identified that he/she was sitting at the nursing station, charting and observing Patient #51 in the quiet room via video monitor. RN #31 observed the patient stand and ran to the quiet room to intercede. The patient was on the floor, in a prone position, close to the wall, his/her head appeared hyperextended, backwards, almost touching the wall. Although the patient did not readily respond, he/she did identify that his/her head hurt.

Interview with RN #32 on 2/23/18 on 10:00 AM identified that he/she was one of two RN's assigned to the unit on the night of 3/7/18 through 3/8/18 and was the designated charge nurse. He/she had observed Patient #51 in the quiet room and had received report regarding his/her psychotic behavior. RN #32 had observed the patient's unsteady gait as two other RNs assisted Patient #31 to the bathroom. The patient was on q 15 minute checks and was being monitored via video cameras. After toileting the patient, the patient appeared to be at significant risk to fall. RN #32 requested a continuous observation sitter, but was informed that none were available, so RN #31 and RN #32 enlarged the video surveillance picture to include a full screen view of Patient #51 in the quiet room and provided more frequent observation as was possible given the staffing level of two RN's (no mental health workers were assigned to the unit). RN #32 was performing safety checks when RN #31 observed the patient stand and found him/her on the floor.

A CT of the head without contrast dated 3/8/18 at 3:28 AM identified a small left high convexity subarachnoid hemorrhage. The patient was transferred to Acute Care Hospital #2 for further evaluation and treatment as indicated. A discharge summary from acute care hospital #2 dated 3/13/18 identified discharge diagnoses of subarachnoid hemorrhage, and bipolar depression with no neurological deficits. Patient #51 was considered stable for discharge and discharged home.

Interview and review of the CT scan results with the Director of Radiology, MD #32, on 3/22/18 at 3:00 PM identified that the scan was consistent with a small area of blood in the space around the brain coming from either a vascular malformation or a fall. Sloshing of the brain could cause this type of hemorrhage. According to MD #32, another CT scan performed on 3/8/18 at 2:30 PM identified that the hemorrhage had resolved.

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Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

11. Based on clinical record review, facility documentation and interviews for 1 of 3 sampled patients (Patient #3) reviewed for medication administration, the facility failed to ensure home medications were reconciled accurately resulting in missed doses. The findings include:
 - a. Patient #3 was admitted on 2/15/18 and underwent an anterior cervical disc fusion. Patient #3's medical history included spinal stenosis, hypertension and Parkinson

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disease.

The History and Physical progress notes validated by MD #7 on 2/15/18 identified current medications included Carbidopa-Levodopa (Sinemet) 25-100mg and Carbidopa-Levodopa ER (Rytary) 36.25-145 mgs capsule.

The Medication Documentation Review Audit dated 2/15/18 identified RN#4, the Anesthesiologist (MD#8) and MD#7 reviewed and verified Patient#3's home medications by name, dosage and last dose. The document identified Carbidopa-Levodopa (Sinemet) 25-100mg per tablet, two (2) tablets by mouth every day in the morning, 2 tablets at noon, 1 tablet at 7:00PM and 1 tablet at 10:00PM; last dose was taken 2/15/18 at 5:00AM. The document further identified Carbidopa-Levodopa ER (Rytary) 36.25-145 mgs capsule, take 1 tablet by mouth nightly; last dose taken 2/14/18 at 10:00PM.

The physician's order dated 2/15/18 directed Carbidopa-Levodopa (Sinemet) 25-100mg 2 tablet, twice daily, Carbidopa-Levodopa (Sinemet) 25-100mg per tablet 1 tablet, twice daily. Review of the Medication Administration report identified Carbidopa-Levodopa (Sinemet) 25-100mg 2 tablet and Carbidopa-Levodopa (Sinemet) 25-100mg per tablet 1 tablet were administered as ordered from 2/15/18 thru 2/19/18.

The facility was unable to provide evidence that the patient had received Carbidopa-Levodopa ER (Rytary) 36.25-145 mgs capsule, resulting in 4 missed opportunities from 2/15/18 to 2/18/18.

Review of facility documentation identified an order clarification for Carbidopa-Levodopa (Sinemet) 25-100mg and Carbidopa-Levodopa ER (Rytary). The documentation noted that MD#6 approved the request to discontinue the long acting medication taken at 10PM.

In an interview and clinical record review on 4/12/18 at 10:30AM, MD#6 identified he was the covering hospitalist on 2/15/18. MD#6 further identified he cannot recall Patient#3 but upon clinical record review it appears that Pharmacist #1 had entered the orders as a telephone order with read back after he had confirmed them. In addition, MD#6 identified the effect of missing a dose of Sinemet ER depends on the severity of the Parkinson's disease.

In an interview and clinical record review on 4/12/18 at 1:15PM, Pharmacist #1 identified the usual procedure for medication reconciliation is for the admitting physician to review the patient's medication list and decide if home medications are to be continued. Pharmacist # 1 identified upon review of the Patient #3's medication order, it was noted that the orders did not match the home medication list. Pharmacist #1 identified she had contacted the unit RN to confirm the patient's home medication list and then MD#6 who approved to discontinue the long acting Carbidopa-Levodopa ER (Rytary). Pharmacist #1 further identified that the Carbidopa-Levodopa ER is a non-formulary medication and not available in the hospital pharmacy.

Review of the Medication Reconciliation policy identified in part a home medication list will be compiled by interviewing the patient, medication reconciliation will occur at the beginning of the encounter and the RN, prescribing practitioner and Registered Pharmacist may gather a list of the patient's medications.

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12. Based on clinical record review, facility documentation and interviews for ____ of ____ sampled patients (Patient #22) reviewed for fall risk, the facility failed to provide the appropriate supervision and/or assistance while ambulating the patient. The findings include:

a. Patient #22 was admitted on 4/10/18 and underwent a left robotic assisted total knee arthroplasty.

The physician order dated 4/10/18 directed activity beginning post op day #1 to ambulate in room progressing to hallway with assistive device four times daily (including physical therapy (PT) when PT advises.

The physical therapy progress notes dated 4/11/18 at 10:15AM identified the patient ambulated approximately 20 feet and reported onset of lightheadedness. Upon return to his/her room orthostatic blood pressures were obtained and noted to be negative for orthostasis. The note identified the patient agreed to another walk and tolerated 85 feet without incident.

Observations on 4/11/18 at 10:25AM identified Patient#22 ambulating in the hallway with the assistance of a rolling walker and PT#2. Observations identified the patient was being guided by PT#2 holding onto the patient's clothing without the benefit of a gait belt.

In an interview on 4/11/18 at 10:40AM, PT#2 identified the patient talked about lightheadedness but has been doing well. PT#2 identified she knew from her previous encounter with the patient a gait belt was not required because the patient's muscles are strong and his/her blood pressure readings are within normal limits. PT#2 further identified the rationale for not using a gait belt included her clinical judgement, that the gait belt does not hold good and that it is time consuming to clean the belt.

In an interview on 4/11/18 at 11:00AM, the Supervisor for Rehabilitation Services identified staff are encouraged to use a gait belt when ambulating with a patient in accordance with the facility practices.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (f) Diagnostic and Therapeutic facilities.

13. Based on clinical review of the radiological services, the hospital failed to ensure that appropriate approvals were obtained for the use of protective clothing and/or equipment. The findings include:

a. On May 3, 2018 as part of the periodic hospital licensure inspection, the Nuclear Medicine and Radiology Departments of St. Backus Hospital were inspected for compliance with Sections 19-24-1 through 19-24-14 of the Connecticut Administrative Regulations.

The inspection consisted of a review of records, procedures, equipment and facilities, including the following: (a) in-house physics reports and follow-up corrective actions; (b) personnel dosimetry records; records of receipt of radioactive materials; (d) quarterly

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inventories; (e) records of area surveys; (f) records of calibration of available radiation detection instrumentation; (g) calibration of the dose calibrator, including linearity, and constancy determinations; and (h) leak test records.

In the Radiology Department, one item of non-compliance was identified within the scope of the inspection.

- 1) R.C.S.A 19-24-5(c)(3) requires that no allowance shall be made for use of protective clothing or equipment or particle size except as specifically approved by the department.

Contrary to the above, Backus Hospital is taking credit for personnel dose reduction calculations without receiving written prior approval from DEEP.

The following are violations of the State of Connecticut Public Health Code Section 19-13-D3 Short Term Hospitals, General and Special (a) Physical Plant (2) & (i) General (6).

14. Based on observations made during tour of the William W. Backus Hospital on 04/10/18 & 04/11/18 and subsequent documentation review on 04/11/18, the facility failed to ensure that the physical plant was maintained in such a manner as to promote the safety of patients. These findings include:

- a. The surveyor while accompanied by the Life Safety Coordinator observed that every electric, patient bed that was inspected over 2 (two) days of tour was not provided with a current, non-expired, electrical safety inspection placard and the surveyor was not provided with documentation to indicate that testing intervals for this equipment were established with policies and protocols and that inspection, maintenance and testing of all patient care electrical appliances at the facility is being conducted as required by section #'s . 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 & 10.5.8 of NFPA 99, "*Health Care Facility's*"; i.e. beds last done in 05/16-due in 05/17;
- b. The surveyor while accompanied by the Life Safety Coordinator observed that electrical blanket and fluid warmers throughout the Operating Room Suites were being maintained & used in accordance with "*CT Public Health Code*", section # 19-13-D3 (a) Physical Plant (i) General (6); i.e. temperature tracking system adopted by facility-fluid warmers above posted temperatures and system sends no alarms to staff;
- c. The surveyor while accompanied by the Life Safety Coordinator observed that the Anesthesia Work Room located in the "C" Building on the 1st floor level is greater than 50 square feet in floor area and is used for the storage of combustible materials and the doors were not provided with a self-closing device, as required by section # 19.3.2.1 of the "*Life Safety Code*"; i.e. the arms on both doors have been removed from the self-closing devices;
- d. The surveyor was not provided with documentation from the (Davita) Bio Med Technician to indicate that the results of the semi-annual, A.A.M.I. chemical analysis are shared with the Dialysis Nursing (B Building-3rd floor, room # 336B) Units' Medical Director, as required by "*CT Public Health Code*"; i.e. October 2017 results report

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misplaced-not in binder-copy that indicates medical director has reviewed is not available;

- e. The surveyor was not provided with documentation from the Life Safety Coordinator to indicate that all employees are periodically instructed and kept informed with respect to their duties under the facility emergency plan(s) ,as required by section # 19.7.1.2 of the referenced, "*Life Safety Code*";i.e. the facility uses a web-based training tool that reports staff members have met the requirements when in fact-they are allowed to go longer than annually with respect to their duties under the facility emergency plan.

Backus
Hospital

A Hartford HealthCare Partner

Approved
10/1/18
STN

September 14, 2018

Susan Newton RN, B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: Plan of Correction in response to DPH violation letter

Dear Ms. Newton,

Thank you for your August 23, 2018 violations letter describing the Department of Public Health findings related to the unannounced visits at The William Backus Hospital on April 9, 10, 11, 12; March 22, and June 5, 2018 for the purpose of conducting our licensing inspection along with several investigations.

We appreciate your email response allowing us until September 14, 2018 to respond.

In response to the violations, attached please find our Plan of Correction. This is being sent to you in accordance with instructions outlined in the letter dated August 23, 2018.

Should you require any additional information, please do not hesitate to contact me or Peg Basch, Director of Quality & Safety (860-456-6842).

Sincerely,

Laura Currie

Laura Currie RN, MS
Vice President of Patient Care Services
Hartford Healthcare, East Region

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services.

1. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for pain (Patient #8), the hospital failed to ensure the patient's pain monitored and/or efficacy of interventions were assessed. The finding includes the following:
 - a. Patient #8 presented to the ED on 4/8/18 at 1:11 PM with complaints of back pain. Review of the record with the Nurse Manager on 4/9/18 at 10:00 AM indicated that on 4/8/18 at 1:22 PM the patient had a pain level of 9 (0-10 scale) and Robaxin was administered at 2:03 PM and a Lidoderm patch was applied at 3:14 PM. The record failed to reflect a reevaluation of the patient to determine the efficacy of the Robaxin until 4/9/18 at 3:05 AM when the patient had a pain level of 7. Review of the policy indicated in part that staff should reassess the patient for pain after each pain management intervention within two hours after IM, SC or oral medications or prior to discharge.

The following plan has been put into place:

Responsible Person: Nurse Manager, Emergency Department

Measures to prevent the reoccurrence: Emergency Department nursing staff was re-educated on our Pain Management Policy via email on 9/11/2018. In addition to the requirement to review the Pain Management Policy, key elements were highlighted in an additional document for review. This has also been a focus within the huddles in the Emergency Room. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions.

Sustainment: Random audits of 10 charts /month for three consecutive months with a goal of at least 90% compliance for documentation of pain assessment & reassessment.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (c) Medical staff (2) and/or (4) (A) and/or (d) Medical records (3) and/or (i) General (6).

2. Based on a review of clinical records, interview and policy review, for one patient receiving mechanical ventilation (Patient #15), the hospital failed to ensure that the Mechanical Ventilation Protocol was comprehensive. The finding includes the following:
 - a. Review of Patient #15's clinical record indicated that the patient was intubated on 4/4/18 requiring mechanical ventilation. The physician's order directed "Mechanical Ventilation Protocol". Review of the protocol indicated that for FiO₂ (fraction of percentage of inspired oxygen) initial setting should be 40%-100 % to maintain the patient's oxygen saturation greater than 90%. Review of Patient #15's respiratory record for the period of 4/4/18 through 4/7/18 indicated that the patient was initially set at 50% with a saturation of 97%, was decreased 45% on 4/5/18 and on 4/6/18 was changed to 55% based on a saturation of 92%. The protocol failed to direct the increments/decrement amount when making changes.

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Interview with the Director of Respiratory Services on 4/10/18 at 10:30 AM indicated that the standard is to change the FiO2 by 10% however this is not in the protocol.

The following plan has been put into place:

Responsible Person: Manager of Respiratory Therapy

Measures to prevent the reoccurrence: The Mechanical Ventilation Document was reviewed, revised, and approved by our MEC on 6/20/2018. Following the revision, staff was educated on the changes in this policy at Lean Daily Management Huddles over a period of 2 weeks. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions. They also received the revised policy via email on 5/11/2018 and again on 9/5/2018 in order to capture a read receipt.

Sustainment: Random audits to evaluate the compliance with using the Ventilator Protocol. This will encompass 5 opportunities a month for 3 months looking for 100% compliance with incremental/decremental changes to the patient's FiO2 settings.



The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

3. Based on a review of clinical records, and policy review, for one patient in restraints, (Patient #5), the hospital failed to ensure the patient was monitored in accordance with facility policy. The finding includes the following:

a. Patient #5 presented to the ED on 3/20/18 at 12:35 PM with alcohol intoxication. The record indicated that the patient was placed in four point restraints at 2:25 PM secondary to the behaviors of hitting, kicking and biting. The record indicated that the patient was monitored at the initiation of the restraints then again at 6:37 PM (four hours later) when range of motion was evaluated.

Review of the policy indicated patients in behavioral restraints are to be monitored every fifteen minutes for, in part, patient dignity and respirations. The policy further directed that patients should be monitored every two hours, in part, for vital sign assessments, elimination, injury, hygiene, and fluid needs.

The following plan has been put into place:

Responsible Person: Nurse Manager, Emergency Department

Although this patient was monitored every 15 minutes and documentation of this monitoring occurred timely, and per policy, there was a missed opportunity for one 2 hour documentation requirement.



Measures to prevent the reoccurrence: Our Emergency Department nursing staff was re-educated on our Restraint & Seclusion Policy via email on 9/11/2018. In addition to the requirement to review the Restraint & Seclusion Policy key elements were highlighted in an additional document for review, including screen shots taken from EPIC. This topic has also been a focus within the huddles in the Emergency Room. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions.

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Sustainment: Random audits of 10 charts /month for three consecutive months with a goal of at least 90% compliance for documentation of the required elements for restraint monitoring.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1).

4. Based on a review of clinical records, and policy review, for one patient receiving hemodialysis, (Patient #16), the hospital failed to ensure the patient was weighed post treatment. The finding includes the following:
 - a. Patient #16 was admitted to the facility on 3/28/18 and required hemodialysis. Review of the hemodialysis flow sheets dated 3/29/18, 3/30/18 and 3/31/18 failed to identify that post-treatment weights were obtained.
The Post Treatment Patient Assessment Policy identified that a post treatment assessment is conducted, in part, to evaluate the effectiveness of the treatment and that patient care staff will obtain and document basic data on each patient including a post dialysis weight and compare to the pre-dialysis findings.

The following plan has been put into place:

Responsible Person: Hospital Services Administrator (DaVita)

Upon additional review of the Hemodialysis flow sheets for patient #16, documentation was present on 3/29/2018 that a weight was unable to be obtained. Reason for not obtaining weight was not documented and additional attempts to weigh patient could not be found. Within the hemodialysis flow sheets dated 3/30/2018 and 3/31/2018, there was clear documentation of a pre and post weight.

Measures to prevent the reoccurrence: The dialysis staff routinely obtains weights both pre-treatment and post treatment. There are circumstances when a weight is not able to be obtained, for example if the bed scale is not functioning or if the patient is not able to stand to obtain a weight. The DaVita dialysis staff received re-education during a staff meeting on 9/11/2018 to be sure to document pre and post weights along with a rationale if not able to obtain one.

Sustainment: Random audits of at least 10 charts per month for 3 months looking for at least 90% compliance for pre and post weights or documentation of why weight was not able to be obtained.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (c) Medical staff (2) and/or (4)(A) and/or (d) Medical records (3) and/or (e)
Nursing Services (1) and/or (i) General (6).

5. Based on a review of clinical records, interview and policy review, for one of three patients' reviewed with complaints of chest pain, (Patient #35), the facility failed to ensure that an EKG was obtained timely and/or that abnormal vital signs were re-evaluated timely. The findings include the following:
 - a. Patient #35 presented to the ED on 2/22/18 at 9:50 AM with a complaint of "trouble breathing, feels like trouble with heart". The patient had a medical history in part, diabetes, sleep apnea, coronary artery disease, chronic obstructive pulmonary disease,

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and congestive heart disease.

- i. The triage note on 2/22/18 at 9:59 AM indicated that reason for the visit was difficulty breathing for one week, swelling ankles and chest tightness. The patient was designated as a level three (3) acuity. Review of systems by the ED physician dated 2/22/18 at 12:15 PM indicated that the patient was positive for shortness of breath (SOB), negative for cough, and chest pain. Physical exam indicated a cardiac assessment of normal rate and rhythm, pedal edema and normal breath sounds.

Review of the physician orders at 9:59 AM, directed that an EKG be obtained. The record indicated that an EKG was completed at 12:10 PM, two hours after presentation. Interview with the triage nurse on 6/5/18 at 10:50 AM stated she did not remember the patient however when an EKG is ordered in triage, one of the technicians are directed to obtain the EKG. Interview with the ED Medical Director on 6/5/18 at 11:15 AM stated that the door to EKG time should be less than 10 minutes.

Review of the ED policy for assessments/ reassessments directed that patients will be seen after a short registration and that treatment will be determined by the severity of the presenting medical problem.

- ii. Review of Patient #35's vital signs indicated that at 10:00 AM the patient had a blood pressure of 182/125, pulse of 103, and respirations of 24. The record failed to reflect that the patient's blood pressure was reassessed until 12:02 PM, two (2) hours later. Interview with the Associate ED Director on 6/5/18 at 11:15 AM indicated that vital sign reassessment is an area of focus.

Review of the ED policy for assessments/reassessments indicated that the registered nurse will ensure that abnormal vital signs are repeated within 30-60 minutes.

The following plan has been put into place:

Responsible Person: Nurse Manager, Emergency Department

An evaluation of staffing in our ED was completed and staffing resources have been re-adjusted and redistributed in order improve our patient flow in our Emergency Department. As we continue to implement Lean Strategies, one of our daily drivers focuses on the metric of Door to EKG time. By doing this, we monitor very closely this process and can evaluate in real time any cases that fall outside our goal for obtaining an EKG on appropriate patients.

Measures to prevent the reoccurrence: Re-education was provided to our ED nursing staff on timely completion of EKGs ordered. Part of this education included standard work to outline the process around obtaining an EKG. Re-education also occurred to ED Nursing staff of Policy Assessment and Reassessment of Patients. Emergency Department. This education went out via email on 9/11/2018. This

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information was also discussed at daily huddles. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions.

Sustainment:

Random audits of 10 charts /month for 3 months with a goal of at least 90% compliance for timely completion of EKG's. Goal < 10 min.

Random audits of 10 charts/month for 3 months looking for a re-assessment of vital signs per policy looking for at least 90% compliance.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

6. *Based on medical record reviews, review of facility documentation, review of facility policies and interviews for one of three surgical patients (Patient #4), the facility failed to ensure that objects were not unintentionally retained. The finding includes:

a. Patient #4 was admitted to the hospital on 3/30/18 for a hemorrhoidectomy. The final surgical sponge count conducted by RN #2 and ST (Surgical Technician) #1 and documentation by RN #2 on 3/30/18 at 1:55 PM identified that the final sponge count was incorrect. The intraoperative record dated 3/30/18 identified that Patient #4 left the OR at 2:08 PM and arrived in the PACU (post- anesthesia care unit) with CRNA #1 (certified registered nurse anesthetist) at 2:13 PM. RN #2's addendum to the OR record dated 3/30/18 at 4:45 PM indicated that Patient #4 emerged from anesthesia in a thrashing manner in the OR which required immediate attention (by RN #2 and ST #1) for patient safety. Patient #4 was then transported to the PACU with CRNA #1 and upon returning to the surgical count, a Raytech 8 x 4 sponge was found missing. The progress note by MD #2 dated 3/30/18 at 2:46 PM identified that he was informed of the missing sponge when the Patient was in PACU, Patient #4 was immediately informed and taken back to the OR. Patient #4 received Propofol anesthesia, proctoscopy was performed and the retained sponge was removed. Interview with the Regional Director of Quality on 4/9/18 at 9:27 AM identified that she interviewed CRNA #1 after the incident and CRNA stated that she left the OR with Patient #1 because she believed that the final count had been completed. Interview with RN #2 on 4/12/18 at 10:10 AM noted that the sponge count was interrupted due to patient safety, MD #2 had left the room prior to the count completion and she did not realize that CRNA #1 and Patient #4 had left the OR. Interview with MD #2 on 4/12/18 at 11:58 AM indicated that he debriefed the team at the end of the OR case, left the OR, assumed that the final surgical count was in process and was informed of the inaccurate count when he was in PACU. Interview with the Director of Surgical Services on 4/12/18 at 10:46 AM noted that the universal protocol policy was not followed by the OR staff for this procedure. Interview with the Vice President of Medical Affairs on 4/12/18 at 1:52 PM noted that the operating surgeon was ultimately responsible for the care of the patient. The facility universal protocol policy identified that all surgical/procedural team members should participate in sign-out and de- briefing which shall address, in part, completion of sponge, sharps, instrument count or accounted for, including intentionally retained items inserted/or

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removed.

The following plan has been put into place:Responsible Person: Nurse Manager. Operating RoomMeasures to prevent the reoccurrence:

1. The incident of the retained sponge was discussed at the daily huddle on 4/2/2018. Staff were reminded to verbally communicate to all members of the team in the OR if the count was not correct. This discussion also included a reminder that the patient is not to leave the OR unless count is confirmed and correct.
2. A "Learning Moment" (a visual display of information) was placed on huddle board for review by staff on 4/9/2018. This document reviewed the event and the plan for corrective actions to prevent reoccurrence, which included a revision of the count policy, a review of additional educational opportunities, and a focus on our de-briefing process.
3. The count policy was revised, which was completed on May 31, 2018. Education regarding this revised policy was provided to the operating room staff. This education was completed by all on June 15, 2018.
4. The Universal Protocol Policy was sent out via Healthstream for staff to review on 4/9/2018 with completion by 4/30/2018.
5. The Medical Staff received education related to our Universal Protocol at their staff meeting on 4/16/2018.

Sustainment: Random audits/ 10 per month for 3 months looking for 100% compliance with assurance that the counts have been complete prior to the patient leaving the operating room. These audits were completed in May, June, and July showing 100% compliance.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (a) Physical plant and/or (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

7. *Based on medical record reviews, review of facility documentation and interviews, the facility failed to ensure that the environment was safe on the BHU (behavioral health unit). The finding includes:

- a. Patient #14 was admitted to the medical unit on 3/30/18 with SI (suicidal ideation), depression and tachycardia. Patient #14 was placed on one to one observation. Patient #14 also had a recent history of suicidal attempt by hanging. Following medical clearance, Patient #14 was admitted to the BHU on 4/2/18 at 7:01 PM. The initial psychiatric assessment by MD #5 dated 4/2/18 identified that Patient #14 was at low risk for suicide due to being hospitalized. Nursing documentation dated 4/2/18 at 7:00 PM identified that Patient #14 had SI and would contact a staff member if he/she felt like hurting self.

Patient #19 had a history of at least 2 suicide attempts and was admitted to the medical

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unit on 4/1/18 with diagnoses that included alcohol abuse, seizures, depression, SI and was placed on one to one observation. Patient #19 was medically cleared and was admitted to the BHU on 4/4/18 at 2:56 PM. The initial psychiatric assessment by MD #5 dated 4/4/18 identified that Patient #19 had suicidal ideation with a suicidal plan of hanging and was at low suicide risk due to hospitalization.

A tour of BHU was conducted with the Unit Manager on 4/9/18 beginning at 9:35 AM. Observations identified that the unit had five occupied medical beds. The observations further identified that although modifications had been made to the beds to include shortened, secured cords and non-removable head and foot boards, multiple ligature points were observed on the bed frames and side rails. The observations also noted that Patients #14 and #19 occupied two of the five medical beds. Review of facility documentation and interview with the BHU Manager on 4/11/18 at 1:22 PM noted that the medical beds had been on the BHU at least three years. Interview with MD #5 on 4/12/18 at 11:12 AM indicated that although she was unaware of the ligature points on the medical beds, she was aware that Patients #14 and #19 were placed in medical beds on the BHU and both patients felt safe in the hospital. Interview with the Regional Director of Quality and Safety on 4/11/18 at 2:15 PM and review of facility documentation indicated that an environmental risk assessment of the BHU was not conducted during 2017, was conducted on 1/31/18 and although the safety of the medical beds was discussed, the discussion or risk assessment had not been documented. Subsequently on 4/12/18, the facility began to replace the medical beds on the BHU.

The following plan has been put into place:

Responsible Person: Nurse Manager, Behavioral Health

An environmental risk assessment was completed on 1/31/18. Although the medical beds were identified as ligature risks, they were not added to the assessment document at that time. During survey, the medical beds were added to this Risk Assessment. Behavioral Health partners with facilities management to mitigate safety risks identified in the department on a continuous basis with documentation of updates in our electronic system.

Measures to prevent the reoccurrence: Five new behavioral health medical beds were purchased. They were delivered and put into use September 2018. Criteria for patient placement into medical beds has been created & staff educated via Daily Huddles. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions. This also includes the importance of performing a risk assessment of a roommate of a patient placed in a medical bed. Information regarding behavioral health medical beds was provided via newsletter "Mental Health Matters" on 4/12/2018 and 4/27/2018. Hourly environmental rounding and patient safety checks continue.

Sustainment: Random audits of environmental rounding checklist, patient safety checks, and appropriateness of placement of patients in a medical bed (10 opportunities) for three consecutive months with a goal of 100% compliance.

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b. A tour of BHU was conducted with the Unit Manager on 4/9/18 beginning at 9:35 AM. Observations at 9:40 AM identified that the handicap shower room door was unlocked, partially open and unattended. Observation of the handicap shower room noted multiple ligature points to include sink hardware. Interview with the BHU Manager on 3/9/18 at 9:35 AM noted that the door to the shower room was to be kept locked when unattended and patients were always supervised when in the room. The BHU Manager subsequently closed and locked the handicap shower room door. The BHU environmental rounds sheet identified hourly rounding to ensure that the handicap shower room was locked and rounds were last conducted on 4/9/18 at 9:00 AM to indicate that the door was observed locked.

The following plan has been put into place:

Responsible Person: Nurse Manager, Behavioral Health

During survey the door to the handicapped shower was found unlocked and slightly ajar as it was in the process of being prepared for one of our patients. When found open and unlocked, it was locked immediately.

Measures to prevent the reoccurrence: Education about this finding and importance of maintaining a locked door to this handicapped shower was provided to staff via a Newsletter "Mental Health Matters" on April 13, 2018. Unit Safety Checks or environmental hourly rounds are done and they include confirmation that the shower door is locked. These rounds continue.

Sustainment: Random audits (5 times/month) specific to the shower door being locked will be accomplished by the Nurse Manager with a goal of at least 100% compliance.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (i) General (6).

8. Based on medical record reviews, review of facility documentation and interviews the facility failed to ensure that physician restraint orders were complete for 3 of 4 patients (Patients #'s 13, #20 and #21) who were restrained. The finding includes:

- Patient #13 was admitted to the BHU (Behavioral Health unit) with diagnoses included

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psychosis. Patient #13's medical record dated 8/24/17 indicated that the patient was verbally assaultive, attempted physical assault, could not be redirected and was placed in 4-point restraints on 4/24/17 at 8:00 PM. Although the restraint order dated 8/24/17 indicated risk for self- harm/aggressive behavior as the reason for the restraint, the order lacked the behavior(s) that elicited the use of the restraints.

- b. Patient #20 was admitted to the BHU for psychiatric management. Patient #20's medical record dated 7/25/17 indicated that the patient continued to be agitated and aggressive toward staff despite medication administration and was placed in 4-point restraints on 7/25/17 at 9:45 AM. Although the restraint order dated 7/25/17 indicated risk for self- harm/aggressive behavior as the reason for the restraint, the order lacked the behavior(s) that elicited the use of the restraints.
- c. Patient #21 was admitted to the ED on 3/20/18 with alcohol intoxication. Patient #21's medical record identified that the patient was argumentative, hostile and security was present. Physician orders dated 3/20/18 at 2:24 PM directed 4 point restraint and the reason for the restraint was danger to self. The order lacked the behavior(s) that elicited the use of the restraints.

Review of patient restraint orders with the Director of the BHU on 4/12/18 at 11:53 AM noted that a generic reason for behavioral restraint use was present for all behavioral restraint orders, was not specific and required only a check mark by the practitioner. The facility policy for restraint and seclusion identified that the restraint order must include, in part, the reason for the restraint seclusion.

The following plan has been put into place:

Responsible Person: Medical Director Emergency Department
Medical Director Behavioral Health

Our policy, Restraint and Seclusion, does specify that the "reason for restraint/seclusion" is within the order. Our order requires a start time, duration, type of restraint, restraint location, reason for restraint/seclusion, and criteria for discontinuation. We have developed an order set within our Electronic Physician Order Entry specific to the use of restraints/seclusion which includes all elements listed. When an order is placed to apply a Violent/Self Destructive restraint, the order set provides the option for "Reason". The reasons that the provider can choose is either "Danger to self" or "Danger to others". There are behaviors that a patient may exhibit which leads to the use of restraint. The behaviors are typically witnessed and documented by the nurse, although a provider may also witness and document, which would be in a progress note. Behaviors are not required in our order for restraints. We did find in all patients listed above a reason was addressed by the ordering provider. In each case, behaviors were documented by the nursing staff.

Measures to prevent the reoccurrence: We did provide re-education to ED & BH Providers on the required elements for restraint orders to be sure they realized the importance of not missing the requirement to choose a reason. The re-education was sent via an email sent on 8/31/2018 to our ED

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providers and to our Behavioral Health Providers on 9/14/2018.

The following is a violation of the Regulation of Connecticut State Agencies Section 46a-153.

9. Based on medical record reviews, review of facility documentation and interviews the facility failed to ensure that the facility included all required elements in the compilation of restraint use. The finding includes:
 - a. A review of restraint logs for the BHU (behavioral health unit) and ED (emergency department) was conducted on 4/12/18 with the Director of the BHU. The logs identified the following; name of the patient, order date/time, type of restrain, discontinuation date/time length of time in restraints and initials of the staff who initiated the restraint. The review also indicated that the restraint compilation (logs) lacked the nature of the emergency for the use of the restraint.

The following plan has been put into place:

Responsible Person: Nurse Manager, Behavioral Health

Measures to prevent the reoccurrence: At the time of our survey, the restraint log was revised to include the reason for the restraint use which would encompass the nature of the emergency for use. This occurred by April 11. Education was provided to staff via a Newsletter "Mental Health Matters" sent out on April 13, 2018. In addition, this was discussed at daily huddles. Lean Daily Management Huddles are a verbal interaction for exchange of critical information, allowing in the moment clarifications and questions.



Sustainment: Audit of restraint log monthly for 3 months to be sure all elements filled in including reason for restraint, looking for 100% compliance.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

10. Based on observation, review of clinical records, hospital policies and procedures and interviews for one of three patients who received multiple psychotropic medications and utilized the quiet/seclusion room (Patient #51) the hospital failed to provide adequate supervision to mitigate the risk to fall. The findings include:
 - a. Patient #51 was admitted to the in-patient behavioral health unit on 3/06/18 with diagnoses of major depressive disorder and hypothyroidism with chief complaints of increased anxiety and depression with suicidal thoughts. On 3/07/18 at 12:00 AM, Patient #51 presented as anxious, tangential, and reported racing thoughts. A Fall Risk Screen documented at 1:00 AM identified as a low fall risk. On 03/07/18 at 6:36 AM the patient was described as responding to internal visual and auditory stimuli, knocking on egress doors, and searching for people who did not exist. Attempts to redirect were unsuccessful. At 2:08 PM the patient expressed delusional thinking. A Fall Risk

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Screening documented at 7:00 PM identified a low risk score of one. At 10:46 PM the hallucinations and delusions continued, MD #32 was contacted, Patient #51 received Chlorpromazine 50 mg and Diphenhydramine 25 mg intramuscularly and willingly went to the quiet room with the door open.

On 3/8/18 at 12:30 AM, RN #31 documented that Patient #51 was floridly psychotic with visual and auditory hallucinations. He/she required assistance of two staff for ambulation to the bathroom and returned to the quiet room for safety. The patient was described as restless, crawling on the floor, and disrobing. RN #31 documented that a sitter was requested for Patient #51, however none were available, and that staff would continue close observation of the patient.

On 3/8/18 at 1:33 AM, RN #31 identified that the patient remained restless, yelling out at times, talking to him/herself and unable to settle. Lorazepam 2 mg was administered for anxiety/agitation. At 2:00 AM, RN #31 documented that Patient #51 was observed via video monitor from the nursing station to be standing up and while the staff was on route to the quiet room to provide assistance, the patient fell. The patient was observed to be prone on the floor with his/her head against the wall with the neck flexed back. MD #34 was notified and the patient was assessed by MD# 31. A Fall Risk Screening dated 3/8/18 at 2:00 PM identified a high score of thirteen.

Interview with RN #3, the 3:00 PM to 11:00 PM nurse on 3/7/18 identified that Patient #51 began hallucinating after receiving his/her evening medications. A mental health worker (MHA) stayed with the patient and RN #3 contacted MD #32 who ordered an oral antipsychotic medication. The patient tried to enter other patient's rooms and attempted to dig in the floor presenting a danger to his/her self and others. RN #33 again contacted MD #32 who ordered two additional medications to be administered intramuscularly. The patient accepted the medications. RN #33 identified that he/she decided to move the patient into the quiet room for his/her own protection, to decrease stimuli, and be more visible on the video surveillance camera monitor at the nursing station. Patient #51 fell asleep on the mattress positioned on the floor in the quiet. RN #33 identified that the patient did not appear unsteady on her feet prior to falling asleep on the mattress. RN #33 gave report to RN #31 and RN #32.

Interview with MD #33 on 3/22/18 at 11:30 AM identified that Patient #51 exhibited no signs or symptoms of psychosis when he conducted the initial psychiatric evaluation, however, he/she started the patient on Seroquel 100 mg PO qhs for patient complaint of insomnia.

Interview with RN #31 on 3/22/18 at 3:15 PM identified that he/she had worked the night of 3/7/18 into 3/8/18 and received report at approximately 11:45 PM. The report included that Patient #51 had become psychotic after receiving a dose of Seroquel. The patient had been sleeping in the quiet room with the door open and RN #31 assisted him/her to the bathroom as he/she was unsteady with ambulation and required direction.

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Patient #51 could move, but could not stand unassisted. The patient was crawling on the floor, disrobing, and attempting to stand. RN #31 identified that he/she was sitting at the nursing station, charting and observing Patient #51 in the quiet room via video monitor. RN #31 observed the patient stand and ran to the quiet room to intercede. The patient was on the floor, in a prone position, close to the wall, his/her head appeared hyperextended, backwards, almost touching the wall. Although the patient did not readily respond, he/she did identify that his/her head hurt.

Interview with RN #32 on 2/23/18 on 10:00 AM identified that he/she was one of two RN's assigned to the unit on the night of 3/7/18 through 3/8/18 and was the designated charge nurse. He/she had observed Patient #51 in the quiet room and had received report regarding his/her psychotic behavior. RN #32 had observed the patient's unsteady gait as two other RNs assisted Patient #31 to the bathroom. The patient was on q 15 minute checks and was being monitored via video cameras. After toileting the patient, the patient appeared to be at significant risk to fall. RN #32 requested a continuous observation sitter, but was informed that none were available, so RN #31 and RN #32 enlarged the video surveillance picture to include a full screen view of Patient #51 in the quiet room and provided more frequent observation as was possible given the staffing level of two RN's (no mental health workers were assigned to the unit). RN #32 was performing safety checks when RN #31 observed the patient stand and found him/her on the floor.

A CT of the head without contrast dated 3/8/18 at 3:28 AM identified a small left high convexity subarachnoid hemorrhage. The patient was transferred to Acute Care Hospital #2 for further evaluation and treatment as indicated. A discharge summary from acute care hospital #2 dated 3/13/18 identified discharge diagnoses of subarachnoid hemorrhage, and bipolar depression with no neurological deficits. Patient #51 was considered stable for discharge and discharged home.

Interview and review of the CT scan results with the Director of Radiology, MD #32, on 3/22/18 at 3:00 PM identified that the scan was consistent with a small area of blood in the space around the brain coming from either a vascular malformation or a fall. Sloshing of the brain could cause this type of hemorrhage. According to MD #32, another CT scan performed on 3/8/18 at 2:30 PM identified that the hemorrhage had resolved.

Responsible Person: Nurse Manager, Behavioral Health

The following plan has been put into place:

A thorough review of this patient's fall was completed, including a review of the surroundings where this patient had the fall. Following our review, it was determined that we had placed the patient in the safest environment based upon exhibited behaviors which were said to be "agitated" and "psychotic". This patient (#51) was monitored via camera/monitors by staff, which was about 10-15 feet away from the

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patient. Staff responded as soon as this patient began to make attempts to stand.

Measures to prevent reoccurrence:

1. Additional education with focus on falls and fall prevention sent to Behavioral Health Unit staff via Newsletter, "Mental Health Matters". This was sent out to staff March 23, 2018, March 30, 2018, April 6, 2018, April 13, 2018 and April 27, 2018.
2. A "Read and Sign" that reviews Fall Assessments, Fall Pre-and Post-Documentation, Safety Interventions, and Confusion Assessment Method (CAM) was completed by the Behavioral Health Unit Staff by April 30, 2018.
3. Web based education: Backus Fall Documentation Standards for Nursing Professionals was assigned & completed by D1 Staff. The education was assigned in our web-based training module on 5/28/18. It was completed by 100% of staff by 9/3/2018.

Sustainment: Random audits of 10 charts /month for three consecutive months with a goal of at least 90% compliance for documentation of fall risk assessment and interventions.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

11. Based on clinical record review, facility documentation and interviews for 1 of 3 sampled patients (Patient #3) reviewed for medication administration, the facility failed to ensure home medications were reconciled accurately resulting in missed doses. The findings include:

- a. Patient #3 was admitted on 2/15/18 and underwent an anterior cervical disc fusion. Patient #3's medical history included spinal stenosis, hypertension and Parkinson disease. The History and Physical progress notes validated by MD #7 on 2/15/18 identified current medications included Carbidopa-Levodopa (Sinemet) 25-100mg and Carbidopa-Levodopa ER (Rytary) 36.25-145 mgs capsule. The Medication Documentation Review Audit dated 2/15/18 identified RN#4, the Anesthesiologist (MD#8) and MD#7 reviewed and verified Patient#3's home medications by name, dosage and last dose. The document identified Carbidopa-Levodopa (Sinemet) 25-100mg per tablet, two (2) tablets by mouth every day in the morning, 2 tablets at noon, 1 tablet at 7:00PM and 1 tablet at 10:00PM; last dose was taken 2/15/18 at 5:00AM. The document further identified Carbidopa-Levodopa ER (Rytary) 36.25-145 mgs capsule, take 1 tablet by mouth nightly; last dose taken 2/14/18 at 10:00PM. The physician's order dated 2/15/18 directed Carbidopa-Levodopa (Sinemet) 25-100mg 2 tablet, twice daily, Carbidopa-Levodopa (Sinemet) 25-100mg per tablet 1 tablet, twice daily. Review of the Medication Administration report identified Carbidopa-Levodopa (Sinemet) 25-100mg 2 tablet and Carbidopa-Levodopa (Sinemet) 25-100mg per tablet 1 tablet were administered as ordered from 2/15/18 thru 2/19/18. The facility was unable to provide evidence that the patient had received Carbidopa-

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Levodopa ER (Rytary) 36.25-145 mgs capsule, resulting in 4 missed opportunities from 2/15/18 to 2/18/18.

Review of facility documentation identified an order clarification for Carbidopa-Levodopa (Sinemet) 25-100mg and Carbidopa-Levodopa ER (Rytary). The documentation noted that MD#6 approved the request to discontinue the long acting medication taken at 10PM.

In an interview and clinical record review on 4/12/18 at 10:30AM, MD#6 identified he was the covering hospitalist on 2/15/18. MD#6 further identified he cannot recall Patient#3 but upon clinical record review it appears that Pharmacist #1 had entered the orders as a telephone order with read back after he had confirmed them. In addition, MD#6 identified the effect of missing a dose of Sinemet ER depends on the severity of the Parkinson's disease.

In an interview and clinical record review on 4/12/18 at 1:15PM, Pharmacist #1 identified the usual procedure for medication reconciliation is for the admitting physician to review the patient's medication list and decide if home medications are to be continued. Pharmacist # 1 identified upon review of the Patient #3's medication order, it was noted that the orders did not match the home medication list. Pharmacist #1 identified she had contacted the unit RN to confirm the patient's home medication list and then MD#6 who approved to discontinue the long acting Carbidopa-Levodopa ER (Rytary). Pharmacist #1 further identified that the Carbidopa-Levodopa ER is a non-formulary medication and not available in the hospital pharmacy.

Review of the Medication Reconciliation policy identified in part a home medication list will be compiled by interviewing the patient, medication reconciliation will occur at the beginning of the encounter and the RN, prescribing practitioner and Registered Pharmacist may gather a list of the patient's medications.

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WERE IDENTIFIEDThe following plan has been put into place:

Medication Reconciliation is a multidisciplinary process. A thorough review of this case took place, involving Nursing, Pharmacy, Providers, and Quality. This review was retrospective following our licensure visit. Documentation is present that a medication list was obtained for patient #3. When the prescribing provider entered the order for the medications, it appeared that it did not match the list obtained from the patient on his/her arrival to the hospital. This was realized by a Pharmacist when reviewing the medications. (Prior to the patient being able receive any medications, a pharmacist reviews the list for appropriateness of meds, for example, interactions, allergies, and dosage.) Following the review of this patient's medication orders and medication list, the pharmacist reached out to the provider, but the prescribing practitioner was not available, thus a covering provider was consulted. It was realized during the review of this case, the opportunity for clarity rested with the original prescriber who understood the rationale for ordering the medications as he/she did, not the covering provider. What was ordered initially was Carbidopa-Levodopa (Sinemet) 25-100mg per tablet, two (2) tablets by mouth every day in the morning, and 2 tablets at noon. In addition, Carbidopa-Levodopa (Sinemet) 10-100mg was ordered for nighttime. As Rytary (Long acting Sinemet) is not part of our formulary, it is possible this was chosen as a therapeutic equivalent. (The prescribing provider was not available for clarification of rationale).

The Pharmacist did reach out to the covering provider. The decision was made to continue the Carbidopa-Levodopa (Sinemet) 25-100mg per tablet, two (2) tablets by mouth every day in the morning, and 2 tablets at noon. In addition, to add what was on the list for Carbidopa-Levodopa (Sinemet) 25-100mg one tab at 7:00 PM and one tab at 10:00 PM. The Rytary (which is non-formulary) was not ordered.

Measures to prevent reoccurrence:

As part of our process change, if after review of a patient's medication list and provider's orders, the pharmacist determines a need for review and clarification of medications, every attempt will be made to consult the original prescribing provider. If that is not possible, in consultation with the covering provider, a determination will be made whether it would be appropriate to wait until the following day to speak directly to the original prescribing provider. If there is no potential negative impact identified, the prescribing provider will be contacted to resolve discrepancies.

Pharmacists will be educated to this change in process via email, sent out on September 14, 2018.

Sustainment:

Random audits of 5 charts /month for three consecutive months with a goal of at least 100% compliance with revised process.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (i) General (6).

12. Based on clinical record review, facility documentation and interviews for ____ of ____ sampled patients (Patient #22) reviewed for fall risk, the facility failed to provide the appropriate supervision and/or assistance while ambulating the patient. The findings include:

- a. Patient #22 was admitted on 4/10/18 and underwent a left robotic assisted total knee arthroplasty.

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The physician order dated 4/10/18 directed activity beginning post op day #1 to ambulate in room progressing to hallway with assistive device four times daily (including physical therapy (PT) when PT advises.

The physical therapy progress notes dated 4/11/18 at 10:15AM identified the patient ambulated approximately 20 feet and reported onset of lightheadedness. Upon return to his/her room orthostatic blood pressures were obtained and noted to be negative for orthostasis. The note identified the patient agreed to another walk and tolerated 85 feet without incident.

Observations on 4/11/18 at 10:25AM identified Patient#22 ambulating in the hallway with the assistance of a rolling walker and PT#2. Observations identified the patient was being guided by PT#2 holding onto the patient's clothing without the benefit of a gait belt.

In an interview on 4/11/18 at 10:40AM, PT#2 identified the patient talked about lightheadedness but has been doing well. PT#2 identified she knew from her previous encounter with the patient a gait belt was not required because the patient's muscles are strong and his/her blood pressure readings are within normal limits. PT#2 further identified the rationale for not using a gait belt included her clinical judgement, that the gait belt does not hold good and that it is time consuming to clean the belt.

In an interview on 4/11/18 at 11:00AM, the Supervisor for Rehabilitation Services identified staff are encouraged to use a gait belt when ambulating with a patient in accordance with the facility practices.

The following plan has been put into place:

Responsible Person: Supervisor, Rehabilitation Services

Following review of our current practice, effective September 14, 2018, Physical Therapy staff assisting patients for mobility will utilize a gait belt in their practice for all patients that require assistance during ambulation.

Measures to prevent reoccurrence: The Physical Therapy Staff was provided education via Daily Huddles and also an email containing expectations for gait belt use on September 12, 2018. The expectations going forward (from September 14, 2018) will be that Physical Therapy staff will be required to use a gait belt will be used on all patients unless they are assessed to be independent.

Sustainment: A random visual audit for compliance- 5 patient encounters per month x 3 months looking for 100% compliance.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b)
Administration (2) and/or (f) Diagnostic and Therapeutic facilities.

13. Based on clinical review of the radiological services, the hospital failed to ensure that appropriate approvals were obtained for the use of protective clothing and/or equipment. The findings include:

a. On May 3, 2018 as part of the periodic hospital licensure inspection, the Nuclear Medicine and Radiology Departments of St. Backus Hospital were inspected for

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compliance with Sections 19-24-1 through 19-24-14 of the Connecticut Administrative Regulations.

The inspection consisted of a review of records, procedures, equipment and facilities, including the following: (a) in-house physics reports and follow-up corrective actions; (b) personnel dosimetry records; records of receipt of radioactive materials; (d) quarterly inventories; (e) records of area surveys; (f) records of calibration of available radiation detection instrumentation; (g) calibration of the dose calibrator, including linearity, and constancy determinations; and (h) leak test records.

In the Radiology Department, one item of non-compliance was identified within the scope of the inspection.

- 1) R.C.S.A 19-24-5(c)(3) requires that no allowance shall be made for use of protective clothing or equipment or particle size except as specifically approved by the department.

Contrary to the above, Backus Hospital is taking credit for personnel dose reduction calculations without receiving written prior approval from DEEP.

Responsible Person: Regional Director Diagnostic Imaging

The following plan has been put into place:

A letter was sent September 4, 2018 to the Director, Radiation Division at the Department of Energy and Environmental Protection requesting approval by the Radiation Division of CT DEEP to account for uncorrected occupational exposures received by personnel performing interventional fluoroscopy procedures. We are awaiting a response.

The following are violations of the State of Connecticut Public Health Code Section 19-13-D3 Short Term Hospitals. General and Special (a) Physical Plant (2) & (i) General (6).

14. Based on observations made during tour of the William W. Backus Hospital on 04/10/18 & 04/11/18 and subsequent documentation review on 04/11/18, the facility failed to ensure that the physical plant was maintained in such a manner as to promote the safety of patients. These findings include:

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- a. The surveyor while accompanied by the Life Safety Coordinator observed that every electric, patient bed that was inspected over 2 (two) days of tour was not provided with a current, non-expired, electrical safety inspection placard and the surveyor was not provided with documentation to indicate that testing intervals for this equipment were established with policies and protocols and that inspection, maintenance and testing of all patient care electrical appliances at the facility is being conducted as required by section #'s . 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 & 10.5.8 of NFPA 99, "Health Care Facility's"; i.e. beds last done in 05/16-due in 05/17

The following plan has been put into place:

Responsible Person: Manager, Biomedical Services

Measures to prevent the reoccurrence: Our Biomedical Department collaborated with a contracted vendor for the purpose of completing preventive maintenance on all outstanding beds requiring preventative maintenance. This was completed 4/24/18.

Sustainment: We have inventoried all beds into a new data base. Once the PM has been completed by December 2018, by outside vendor services, each bed listed will be updated as completed. The data base will allow for highlighting any outstanding PMs that need to be accomplished and follow up will occur. Any beds outstanding will be easily identified and then located for PM.

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b. The surveyor while accompanied by the Life Safety Coordinator observed that electrical blanket and fluid warmers throughout the Operating Room Suites were being maintained & used in accordance with "CT Public Health Code", section # 19-13-D3 (a) Physical Plant (i) General (6); i.e. temperature tracking system adopted by facility-fluid warmers above posted temperatures and system sends no alarms to staff;

Responsible Person: Manager, Operating Room

The following plan has been put into place:

Measures to prevent the reoccurrence:

1. Signs were developed to clearly state specific target temperature and acceptable ranges for the fluid and blanket warmers. Signs posted and process discussed with OR staff in huddle on 4/10/2018.
2. Re-education regarding temperature ranges provided to OR staff via huddles and blog sent out 9/7/2018.
3. Adjustments were made within our temperature tracking system to accurately reflect both blanket warming temperatures and fluid warming temperatures effective May 1, 2018. The system alarms at the desk within our operating room. The alarm is responded to by the Unit Coordinator or Charge RN. Any adjustments made are documented within our temperature tracking system.

Sustainment:

Random audits, at 5 different times within a month, of our temperature tracking system will be conducted which will consist of a review of temperature ranges and evidence of an alarm to staff along with an acknowledgement. These audits will occur over 3 months, looking for 100% compliance.

c. The surveyor while accompanied by the Life Safety Coordinator observed that the Anesthesia Work Room located in the "C" Building on the 1st floor level is greater than 50 square feet in floor area and is used for the storage of combustible materials and the doors were not provided with a self-closing device, as required by section # 19.3.2.1 of the "Life Safety Code";i.e. the arms on both doors have been removed from the self-closing devices;

The following plan has been put into place:

Responsible Person: Director, Environmental Health and Safety

Self-closing device re-installed on Anesthesia Work Room, Building C on 4/11/2018 (during survey)

d. The surveyor was not provided with documentation from the (Davita) Bio Med Technician to indicate that the results of the semi-annual, A.A.M.I. chemical analysis are shared with the Dialysis Nursing (B Building-3rd floor, room # 336B) Units' Medical

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Director, as required by "*CT Public Health Code*"; i.e. October 2017 results report misplaced-not in binder-copy that indicates medical director has reviewed is not available;

The following plan has been put into place:

Responsible Person: Hospital Services Administrator

Measures to prevent the reoccurrence: A.A.M.I. Chemical Analysis semi-annual reports have been shared with our Dialysis Units' Medical Director and signatures obtained through April 2018.

Sustainment: The semi-annual reports are completed in April and October. The Hospital Services Administrator will verify signatures have been obtained the first week of the following month that the analysis has been completed. (First week of May and November).

e. The surveyor was not provided with documentation from the Life Safety Coordinator to indicate that all employees are periodically instructed and kept informed with respect to their duties under the facility emergency plan(s) ,as required by section # 19.7.1.2 of the referenced, "*Life Safety Code*";i.e. the facility uses a web-based training tool that reports staff members have met the requirements when in fact-they are allowed to go longer than annually with respect to their duties under the facility emergency plan.

The following plan has been put into place:

Responsible Person: Director, Plant Operations/Safety Officer

According to 19.7.1.2, "All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1." We do have a Fire Prevention Management Plan that was last updated 1/2018. This plan is available to all personnel (in addition to supervisory as required by 19.7.1.1). All staff are periodically instructed and kept informed regarding our Fire Prevention Management Plan. This is accomplished periodically through our web-based training and the training is mandatory for all employees.